Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Pharmacy Fax 800-913-2229

Amerigroup
PA Pharmacy Phone 800-454-3730
PA Pharmacy Fax 844-512-8999

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328

ANTIPSYCHOTIC PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

MEMBER INFORMATION

Name:	Medicaid ID:
Date of Birth:	Gender:

PRESCRIBER INFORMATION

Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:

1. Complete **the Member/Prescriber Information** portion above and **Sections I and II** for **ALL** requests
2. Complete **Section III** if this request requires a **peer-to-peer review**.
3. Complete **Section IV** if this request is a **renewal.**
4. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Name of medication requested: _____

NDC	Strength	Dosage Form	Quantity	Directions for Use

SECTION II: CLINICAL INFORMATION – For ALL Requests

1. Is this a new or renewal request for this medication?
   - ☐ New
   - ☐ Renewal – Proceed to section IV.

PROVIDER TYPE/DIAGNOSIS:

2. Is the patient < 6 years of age? ☐ YES ☐ NO – skip to question 3.
   - A. Document the prescribing physician's specialty.
     - ☐ Developmental-Behavioral Pediatrician ☐ Neurologist ☐ Psychiatrist ☐ Other
       - I. If other: Has the prescribing provider consulted/collaborated with one of the provider specialties listed above in question 2.A.?
         - ☐ YES – If YES, please document the provider's name, specialty and date of consult:
           Provider Name: _____ Specialty: _____ Date of Consult: _____
         - ☐ NO
   - B. Proceed to question 3.
3. Is the patient < 18 years of age? ☐ YES ☐ NO – skip to question 4.
   - A. What is the patient's diagnosis for the requested medication?
     - ☐ Autism Spectrum Disorder ☐ Mood Disorder ☐ Psychotic Disorder ☐ PTSD with Associated Severe Agitation
     - ☐ Tic Disorder (I.E. Tourette's Disorder) ☐ Other – Specify diagnosis: _____
   - B. Proceed to question 5.

PATIENT NAME:		MEDICAID ID:	

SECTION II (CONT.): CLINICAL INFORMATION – For ALL Requests

4. Is the patient ≥ 65 years of age (long-term care, non-dual eligibility group)? ☐ YES ☐ NO – skip to question 5
   A. Please indicate the patient's diagnosis for the requested medication.
      - ☐ Adjunctive Treatment of Major Depressive Disorder
      - ☐ Bipolar Disorder
      - ☐ Huntington's Disease
      - ☐ Irritability Associated with Autistic Disorder
      - ☐ Schizophrenia, Schizoaffective, Delusional Disorder
      - ☐ Tourette's Syndrome
      - ☐ Unspecified Psychotic Disorders
      - ☐ Other – Specify diagnosis: _____

   B. Does the patient have dementia/major neurocognitive disorder with agitation or psychosis whose symptoms present a danger to self or others?
      ☐ YES ☐ NO

MULTIPLE CONCURRENT USE:

5. For patients < 18 years of age, is the patient receiving 2 or more antipsychotics (oral and injectable) concurrently for greater than 90 days? ☐ YES ☐ NO ☐ Patient ≥ 18 years
   A. If **YES**, written peer-to-peer review is required. **Please complete Section III.**
   B. If YES, Is this medication being prescribed by or in consultation/collaboration with a psychiatrist, neurologist or developmental-behavioral pediatrician? ☐ YES ☐ NO

6. For patients ≥ 18 years of age, is the patient receiving 3 or more antipsychotics (oral and injectable) concurrently for greater than 60 days? ☐ YES ☐ NO ☐ Patient < 18 years
   A. If **YES**, written peer-to-peer review is required. **Please complete Section III.**
   B. If YES, Is this medication being prescribed by or in consultation/collaboration with a psychiatrist? ☐ YES ☐ NO

7. For patients ≥ 18 years of age, is the patient receiving 2 or more long-acting injectable antipsychotics concurrently for greater than 60 days? ☐ YES ☐ NO ☐ Patient < 18 years
   A. If **YES**, written peer-to-peer review is required. **Please complete Section III.**

DOSING LIMITATION:

8. Does the dose prescribed exceed the maximum daily dosing limit defined in Table 1 (page 3)? ☐ YES ☐ NO
   A. If **YES**, written peer-to-peer review is required. **Please complete Section III.**

SECTION III: PEER-TO-PEER REVIEW

PLEASE NOTE:

- A written peer-to-peer review will be followed by a verbal peer-to-peer review with a health plan psychiatrist, medical director, or pharmacy director for approval if the written request is not approved.

(Provide any/all clinical rationale/justification for this request (i.e. documentation, chart notes, prior therapy, etc.)

☐ PEER-TO-PEER WRITTEN:

_____

_____

_____

_____

☐ PEER-TO-PEER VERBAL

SECTION IV: RENEWAL CRITERIA

1.	Is the patient stable?	☐ YES	☐ NO
2.	Has the patient been seen by the prescribing provider within the past year?	☐ YES	☐ NO
3.	Does the prescriber ATTEST that he/she has attempted to gather documentation of each of the following within the previous 12 months: fasting plasma glucose, height, weight, lipid screening, abnormal involuntary movement scale (AIMS) evaluation?	☐ YES	☐ NO

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Note – General prescribing recommendations for antipsychotics in all ages:

- Prescriber should attempt to gather fasting plasma glucose, lipid screening, weight, height and Abnormal Involuntary Movement Scale (AIMS) evaluation within the previous 12 months.
- Documentation of developmentally-appropriate, comprehensive psychiatric assessment should be completed by the prescriber and documented in the child's medical record.
- Patient assessment should include DSM-5 or most updated edition of DSM diagnosis, screening for parental psychopathology, evaluation of family functioning and gathering collateral information from community resources (e.g. School).
- Non-psychopharmacological interventions (i.e. training parents or caregivers in evidence-based behavior management) should be initiated before (and maintained, if indicated, during) psychopharmacological treatment is initiated.

TABLE 1. ANTIPSYCHOTIC MEDICATIONS DOSING LIMITS

Drug	Maximum Daily Dose* < 6yrs	Max Daily Dose* 6 To < 10yrs	Max Daily Dose* 10 To < 16yrs	Max Daily Dose* ≥ 16 To Adults
Aripiprazole (Abilify®, Abilify Discmelt®)	15mg	20mg	30mg	45mg
Aripiprazole (Abilify Maintenna®)	Not approved	Not approved	Not approved	400mg per 28 days
Aripiprazole lauroxil (Aristada®)	Not approved	Not approved	Not approved	882mg per 28 days or 1064 every 2 months
Aripiprazole lauroxil (Aristada Initio™)	Not approved	Not approved	Not approved	675 mg single dose
Asenapine (Saphris®)	Not approved	10mg	20mg	20mg
Brexpiprazole (Rexulti®)	Not approved	Not approved	Not approved	4mg
Cariprazine (Vraylar®)	Not approved	Not approved	Not approved	6mg
Chlorpromazine (oral)	40mg	200mg	800mg	1500mg
Clozapine (Clozaril®, Fazaclo®, Versacloz®)	Not approved	300mg	600mg	900mg
Fluphenazine (oral)	Not approved	5mg	10mg	60mg
Fluphenazine HCL and Decanoate (injection)	Not approved	Not approved	Not approved	100mg
Haloperidol (Haldol®)	6mg or 0.15mg/kg/day ("Lesser of")	6mg	15mg	60mg
Haloperidol Decanoate (Haldol® Decanoate)	Not approved	Not approved	Not approved	500mg per 21 days
Iloperidone (Fanapt®)	Not approved	12mg	24mg	24mg
Loxapine (Adasuve®, Loxitane®)	Not approved	30mg	60mg	250mg
Lurasidone (Latuda®)	Not approved	80mg	120mg	160mg
Olanzapine (Zyprexa®, Zyprexa Zydis®)	Not approved	12.5mg	20mg	40mg
Olanzapine pamoate (Zyprexa Relprevv®)	Not approved	Not approved	Not approved	300mg per 14 days or 405 mg every 28 days
Olanzapine/Fluoxetine (Symbyax®)	Not approved	Not approved	12mg/50mg	18mg/75mg
Paliperidone (Invega®)	Not approved	6mg	12mg	12mg
Paliperidone palmitate (Invega Sustenna®)	Not approved	Not approved	Not approved	234mg per 21 days
Paliperidone palmitate (Invega Trinza®)	Not approved	Not approved	Not approved	819mg per 84 days
Perphenazine	Not approved	12mg	22mg	64mg
Pimozide (Orap®)	Not approved	6mg or 0.2mg/kg/day ("Lesser of")	10mg or 0.2mg/kg/day ("Lesser of")	20mg
Quetiapine (Seroquel®, Seroquel XR®)	Not approved	400mg	800mg	1200mg
Risperidone (Perseris™)	Not approved	Not approved	Not approved	120 mg per 28 days
Risperidone (Risperdal®, Risperdal M-Tab®)	1.5mg	4mg	6mg	16mg
Risperidone (Risperdal Consta®)	Not approved	Not approved	Not approved	50mg per 14 days
Thioridazine	Not approved	Not approved	Not approved	800mg
Thiothixene	Not approved	Not approved	15mg	60mg
Trifluoperazine	Not approved	15mg	40mg	40mg
Ziprasidone (Geodon®)	Not approved	80mg	160mg	240mg

*DAILY DOSE UNLESS SPECIFIED